Lung Care &, P.C.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Date of Birth**: _____
Previous Name: _____ **Social Security Number:** _____

I request and authorize [Authorized individual] to release healthcare information of the patient named above to:

Lung Care &, P.C.

_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates

_____

☐ All healthcare information

_____

_____

Definition: Sexually Transmitted Diseases (STD) as defined by the law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

This authorization expires 90 days from the date signed.